

Case Number:	CM15-0184514		
Date Assigned:	09/25/2015	Date of Injury:	01/02/2005
Decision Date:	11/09/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	09/18/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 78 year old female, who sustained an industrial injury on 1-2-05. The injured worker was diagnosed as having thoracic of lumbosacral neuritis or radiculitis, lumbar post-laminectomy syndrome, pain in soft tissues of the limb, pain in joint of the pelvic region and thigh, degeneration of lumbar or lumbosacral intervertebral disc, unspecific osteoporosis, spasm of muscle, and opioid dependence. Treatment to date has included multiple spinal injections, L4-5 fusion, TENS, and medication including Butrans, Cymbalta, Percocet, and Zanaflex. Physical examination findings on 7-22-15 included equal and bilateral intact strength and motor function of bilateral upper and lower extremities. A MRI of the lumbar spine obtained on 3-25-15 revealed mild degenerative changes of the L3-4 disc space with mild neural canal stenosis and bilateral neural foraminal narrowing without evidence of nerve root impingement. On 7-22-15, the injured worker complained of low back and right leg pain. The treating physician requested authorization for an outpatient bilateral S1 transforaminal steroid injection in office. Other requests included a series of 3 transforaminal epidural steroid injections: #1 at right and left S1, #2 at the right and left L4, and #3 at the right and left L5. On 8-13-15, the requests were non-certified; the utilization review (UR) physician noted, "There is an absence of documentation noting evidence of radiculopathy on exam."

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Outpatient bilateral S1 transforaminal steroid injection in office and series of three transforaminal epidural steroid injections, #1 right and left S1, #2 Right and left L4, and #3 right and left L5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: Accordingly, to the MTUS, epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatome distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three." Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007). 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The current request for epidural injection, including three subsequent injections is in contrast to the MTUS guidance above with regard to repeat injection therapy being based on objective documented functional improvement. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established. Therefore, the request is not medically necessary.